

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034293

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 112 Primary Registration District No. 5428 Registrar's No. 19

STATE FILE NUMBER

VS 300  
Rev. 4/59

10360

20360

3

4 1

5 1

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7 0

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9331X

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11

12 90-0

13 2-0

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED OCT 10 1962

## 1. PLACE OF DEATH

a. COUNTY

FRANKLIN

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN

LESLIE, RRI-BOONE LIFE

Length of stay in lb

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

HER HOME

Inside Limits

Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

FRANKLIN

c. CITY

OR TOWN

LESLIE

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)

RRI

Reside on Farm

Yes ☒ No ☐3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

ANNA C. KOELLING

4. DATE OF DEATH

Month

Day

Year

10 2-1962

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

8-14-1882

9. AGE (last birthday)

80

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

FARM

11. BIRTHPLACE (City and state or country)

KBAKOW, MO

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

DAVE

13b. MOTHER'S MAIDEN NAME

ELBERT

14. NAME OF HUSBAND OR WIFE

CATHERINE RUEBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

EMIL KOELLING

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Emil Koelling

Address

Leslie, RRI

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular Accident

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cerebral Arteriosclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8/14/59 to 10/2/62 and last saw him alive on 9/28/62

Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

James A. Shea MD.

(Degree or title)

22b. ADDRESS

Gerald MO

22c. DATE SIGNED

10/5/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

10-5-62

23c. NAME OF CEMETERY OR CREMATORY

ST. PAUL

23d. LOCATION (City, town, or county)

GERALD

(State)

MO

24. FUNERAL DIRECTOR

E. J. Meyer

ADDRESS

Gerald MO

25. DATE RECD. BY LOCAL REG.

10/5/62

26. REGISTRAR'S SIGNATURE

John Charles Finkley

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Stanley E. Meyer*

Licensed Embalmer No. 4639

P. O. Address Union Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.